ID: _____

Iowa Department of Human Services

CERTIFICATION OF NEED FOR INPATIENT PSYCHIATRIC SERVICES

Name of Child_____ Birthdate _____

INDEPENDENT TEAM ASSESSMENT

YES	**NO**	(Please check one choice for each item)
____	____	1. Available community resources for ambulatory care do not meet the treatment needs of this child.
____	____	2. Proper treatment of this child's psychiatric condition requires service on an inpatient basis, under the direction of a physician.
____	____	3. These services can reasonably be expected to improve this child's condition or prevent regression so that the services will no longer be needed.

Physician Name Date

Name and Profession Date

Name and Profession Date

Name and Profession Date

Name and Profession Date

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